STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		044-588	B. WING			C 03/2016
	PROVIDER OR SUPPLIER HEIGHTS HOSPITAL	934 BRIA	DRESS, CITY, ST. RCLIFF ROA A, GA 30306			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
1 000	At the time of the so was in compliance of and Regulations for Facilities for Childre	urvey, Laurel Heights Hospital with Chapter 111-8-68 Rules Residential Mental Health an and Youth, as a result of tion #GA00158002. The abstantiated.	1000			

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-	
-		044-588			02/2	8/2017
	PROVIDER OR SUPPLIER	93/ RDIA	RESS, CITY, S'	TATE, ZIP CODE		
LAUREL	HEIGHTS HOSPITAL		, GA 30306			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
{ 000}	Initial Comments.		{1 000}			200
	A follow-up to the co	omplaint investigation of ucted. No deficiencies were				

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 09/20/2018 FORM APPROVED OMB NO. 0938-0391

	(EACH DEFICIENCY REGULATORY OR LEADING INITIAL Comments A follow-up to the c	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	TION ULD BE	28/2017 (X5) COMPLETION DATE
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PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LEADING INITIAL Comments A follow-up to the c	Y MUST BE PRECEDED BY FULL	PREFI) TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
{N 000}	A follow-up to the c		(N 00			
			(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	00}		
	11/29/16 was conducited.	omplaint investigation of ucted. No deficiencies were				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 04/06/2015 CILITY PFORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION ALT (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED A. BUILDING 11L005 B. WING ED 04/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COL 934 BRIARCLIFF ROAD, NE LAUREL HEIGHTS HOSPITAL ATLANTA, GA 30306 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID Ю (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY N 000 Initial Comments N 000 A recertification survey and follow-up to a complaint investigation (GA00144467) conducted on 12/3/2014 was done on 4/2/15 and the Laurel Heights (PRFT) was in substantial compliance with 42 CFR Part 483, Sub Part G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Twenty One, the following deficiencies were otherwise cited: 483.358(d) ORDERS FOR USE OF RESTRAINT N 143 Corrective Action: Medical Director met with OR SECLUSION all physicians on April 21, 2015 and directed them to verify seclusion/ restraint orders If the order for restraint or seclusion is verbal, the within 24 hours. 4/21/15 verbal order must be received by a registered A separate seclusion/ restraint order form has nurse or other licensed staff such as a licensed been created and will be presented to GOB practical nurse, while the emergency safety for approval on April 30, 2015. The order intervention is being initiated by staff or form will go directly to the physician for immediately after the emergency safety situation signature, no longer requiring the Dr. to ends. The physician or other licensed practitioner review every patient record to verify orders. permitted by the state and the facility to order Once approved, the form will be submitted restraint or seclusion must verify the verbal order for printing and implemented upon receipt. in a signed written form in the resident's record. Target Date of May 30, 2015. 5/30/15 The physician or other licensed practitioner permitted by the state and the facility to order Education: Director of Performance restraint or seclusion must be available to staff for Improvement will meet with current consultation, at least by telephone, throughout the physicians individually to review new period of the emergency safety intervention. process; and will add instruction and competency to new physician orientation by May 30, 2015. 5/30/15 This ELEMENT is not met as evidenced by: Based on record review, observation, and Monitoring: The Risk Manager will complete interview the facility failed to insure that the verbal weekly random audits of seclusion/ restraint orders were being signed by the physician within order forms and report to Medical Director twenty-four (24) hours for six (6) of ten (10) any instances of non-compliance. sampled patients. Medical Records will complete a monthly audit of seclusion/ restraint forms and report Findings include: LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

Any deficiency statement ending with an asterist/(*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35VM11

Facility ID: PRTF001005

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		11L005	B, WING		٥	04/03/2015	
	PROVIDER OR SUPPLIER HEIGHTS HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	SHOULD BE COMPLETION		
N 143	Record review reve 1. Record review for order not signed tim 2. Record review for orders not signed tim 3. Record review for order not signed tim 4. Record review for orders not signed tim 5. Record review for orders not signed tim 6. Record review for orders not signed tim 6. Record review for order not signed tim Interview on 4-1-20 confirmed these find physician that signed facility every day. Review of the policy physical Hold Restrationphysician 's writte	aled the following: or patient #1 revealed six (6) nely. or patient #4 revealed four (4) mely. or patient #5 revealed one (1) nely. or patient #6 revealed four (4) mely. or patient #7 revealed ten (10) mely. or patient #7 revealed one (1) mely. or patient #9 revealed one (1)	N 143	to the PI Committee. Goal of 100% compliance with audits to begin in 3. Responsible Persons: Medical Dire Risk Manager, Director of Health Information	une.		

HEALTHCARE VACUATY TEGULARRINTED: 04/06/2015 DULLION State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING RECEIVED 044-588 04/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE LAUREL HEIGHTS HOSPITAL ATLANTA, GA 30306 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) 1000 Initial Comments. 1000 A relicensure survey was completed on 4/2/15 and Laurel Heithgs (RMHF) was in substantial compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth. The following deficiencies were cited: Corrective Action: The Director of Food 1763 111-8-68-.07(5) Services- Nutrition. 1763 SS=D Services held a training with all dietary staff on April 1, 2015 reviewing the policy 4.1.15 Nutrition. Food services must comply with the 'Infection Control Dietary Services: Food Rules and Regulations for Food Service, Chapter Preparation, Service and Cleanliness'. As an 290-5-14. There must be a provision for planning additional check. and preparation of special diets as needed. Menus shall be evaluated by a consultant dietitian Education: The Director of Food Services and relative to nutritional adequacy at least monthly, Dietitian will develop and educate dietary with observation of food intake and changes seen staff to annual competencies that will include in the patient. review and acknowledgment of policies and 5.1.15 procedures to include 'Infection Control Dietary Services: Food Preparation, Service and Cleanliness'. This RULE is not met as evidenced by: Based on review of facility food temperature log, Monitoring: policies and procedures and interview, the facility failed to ensure that foods served to its patients For the next three months (or until 3 months) were monitored for appropriate temperature in a consistent at 100%) the Food Service Director manner to protect them from potential contagion will check the temperature log daily to assure in thirteen (13) out of twenty-seven (27) meals it is being completed correctly; and if it is not served. will address inconsistencies immediately. The Director of Food Services will submit a Findings include: weekly compliance report to the CEO regarding temperature logs. Tour of the facility's kitchen at 9:50 a.m. on 4/01/2015 with the facility's Dietary Manager and The Director of Food Services will report % review of food temperature logs revealed that compliance to the Infection Control food service personnel failed to record gulde line Committee on a monthly basis. Goal of 100% temperatures for food to be served to residents compliance.

State of GA Inspection Report LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

for four (4) breakfasts, two (2) lunches and seven (7) dinners between 3/18/2015 and 3/26/2015.

TITLE 4/11/15

Responsible Person: Director of Food Services, Dietitian, IC Committee, CEO

(X6) DATE

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STATE FORM

35VM11

If continuation sheet 1 of 3

PRINTED: 04/06/2015 FORM APPROVED

State of	GA. Healthcare Fac	ility Regulation Division				
STATEMEN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		044-588	B, WING		04/0	3/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAUREL	HEIGHTS HOSPITAL		RCLIFF ROA , GA 30306			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
·	revised 3/31/2014 e Dietary Services: For cleanliness' stipular facility that foods such a manner as the and contamination. The Dietary Manage the time of discovered the time of discovered the time of discovered the time of discovered the medical orders shall the physician. Teleptused sparingly and or otherwise qualified the medical staff in The individual received repeated order is conferently in the conference order shall immediate prescribing physicial repeated order is conferently in the signed by the timeframe designate procedures which ever the service of the procedures which ever the service of the procedures which ever the procedures are procedures as procedures are procedured to the procedures are procedured to the procedure and the procedures are procedured to the procedure and the procedures are procedured to the procedures are procedured to the procedures are procedured to the procedure are procedured to	entitled, "Infection Control Food Preparation, Service and ates inpart, "It is the policy of a be prepared and sevrved in to prevent food borne illness". Ger confirmed the findings at ary. Prices- Medical Orders. All be in writing and signed by phone/verbal orders shall be if given only to a licensed nurse ied individual as determined by a accordance with State law. Eving the telephone/verbal ately repeat the order and the an shall verify that the correct. The individual shall document, in the cord that the order was ied. Telephone/verbal orders the physician within the ted in the facility 's policies and ensure that it is done as soon in telephone/verbal orders are signed within the timeframe bolicy, the facility will take	1789	Corrective Actions: Order books are created by the Director of Nursing. The nurse will flag (different color for eaphysician) and the physician will revisign every 24 hours or as soon as post orders will be in the book for seven and then will be removed and filed be night nurse. Implementation date of 2015 Education: Director of Performance Improvement will add instruction and competency to new physician orients May 30, 2015. Monitoring: The DON will complete random audits and report compliance monthly. Goal of 100% compliance Responsible Person: Medical Direct Director of Nursing, Director of Performance Improvement	The night ch ch riew and ssible. days by the May 1, d ation by	5.1.15
	i		į į		'	1

3SVM11

State of	GA, Healthcare Fac	lity Regulation Division				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		044-588	B. WING		04/03/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
LAUREL	HEIGHTS HOSPITAL		RCLIFF RO. , GA 30306	· ·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE .	(X5) COMPLETE DATE
I 789	This RULE is not meased on record reinterview the facility orders were being stwenty-four (24) housampled patients. Findings include: Record review reversel. Record review foorder not signed times. Record review foorders not signed times. Record review foorder not signed times. Record review for order not signed times. Record review for order not signed times. Record review for order not signed times. Record review for orders not signed times.	net as evidenced by: view, observation, and failed to insure that the verbal igned by the physician within urs for six (6) of ten (10) aled the following: or patient #1 revealed six (6) nely. or patient #5 revealed four (4) mely. or patient #6 revealed four (4) mely. or patient #7 revealed four (4) mely. or patient #7 revealed ten (10) mely. or patient #7 revealed one (1) mely. or patient #7 revealed one (1)	1789	Corrective Action: Medical Director mall physicians on April 21, 2015 and different to verify seclusion/ restraint order within 24 hours. A separate seclusion/ restraint order for been created and will be presented to approval on April 30, 2015. The order will go directly to the physician for signo longer requiring the Dr. to review expatient record to verify orders. Once approved, the form will be submitted in printing and implemented upon receip Target Date of May 30, 2015. Education: Director of Performance Improvement will meet with current physicians individually to review new and will add instructions and competer new physician orientation by May 30, Monitoring: The Risk Manager will convectly random audits of seclusion/ reorder forms and report to Medical Dirany instances of non-compliance. Medical Records will complete a monaudit of seclusion/ restraint forms and to the PI Committee. Goal of 100% compliance with audits to begin in Jun Responsible Persons: Medical Director Director of Performance Improvement Director of Health Information, PI Committee of the provent of the p	orm has GOB for form gnature, every for st. The process; ney to 2015. complete straint ector sthly report or, tt/RM,	5.30.15 5.30.15
					1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(3) DATE SURVEY COMPLETED	
		044-588	B. WING			2/2016
	PROVIDER OR SUPPLIER HEIGHTS HOSPITAL	934 BRIA	DRESS, CITY, ST RCLIFF ROA A, GA 30306	TATE, ZIP CODE A D, NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES (ENCY)	ULD BE	(X5) COMPLETE DATE
1 000	At the time of the su was in compliance wand Regulations for	urvey, Laurel Heights Hospital with Chapter 111-8-68 Rules Residential Mental Health an and Youth, as a result of tion #GA0060381.	1000			

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					_ c	
		044-588	B. WING		07/0	6/2017
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
LAUREL	HEIGHTS HOSPITA		RCLIFF ROA , GA 30306	AD, NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
1 000	Initial Comments.		1000			
	was in compliance and Regulations for Facilities for Childre	urvey, Laurel Heights Hospital with Chapter 111-8-68 Rules Residential Mental Health en and Youth, as a result of tion #GA00175500.				

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

If continuation sheet 1 of 1

State of GA. Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		044-588	B. WING		07/29/2015	
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
LAUREL	HEIGHTS HOSPITA		RCLIFF ROA , GA 30306	AD, NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
1 000	Initial Comments.		1 000			
1 763	was in substantial of 111-8-68 Rules and Mental Health Facil a result of complain The following deficie of that survey. 111-8-6807(5) Se Nutrition. Food serve Rules and Regulati 290-5-14. There meand preparation of serve and preparation of ser	vices must comply with the ons for Food Service, Chapter ust be a provision for planning special diets as needed.	1763			
	Menus shall be evaluated by a consultant dietitian relative to nutritional adequacy at least monthly, with observation of food intake and changes seen in the patient.					
	Based on review of procedures, facility record review (#s 1-determined that the	net as evidenced by: the facility's policies and correspondence, medical -10) and staff interview, it was a facility failed to follow its policy of patient's weights every				
	Findings were:					
	entitled Vital Signs, number CRPH4228 revealed that it was nurse to record heig month unless more	y's policy and procedure Height and Weight, Policy 3.0E, revised 07/22/10, the responsibility of the staff ght and weight one time per frequent checks were octor or dietician. The policy				

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COM	SURVEY	
		044-588	B. WING		07/2	29/2015
	PROVIDER OR SUPPLIER HEIGHTS HOSPITAI	934 BRIA	DRESS, CITY, STA RCLIFF ROA , GA 30306			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
1763	stated that height a documented on the medical record upon Review of the CDC graphic sheet revea admission (02/02/1 was not weighed aghis/her weight had on Review of medical refive (5) of ten (10) in and 10) failed to har monthly weights we as dictated by the factor of clinic he/she was unawar were not being perfectived.	nd weight were to be graphic sheet of the patient's n admission and monthly. growth chart and patient #5's led that the patient's weight on 5) was #138.8. The patient gain until 05/22/2015 and dropped to #117. ecords (#s 1-10) revealed that nedical records (#s 1, 2, 4, 5 we documented evidence that are being performed on patients acility's policy. on 07/29/2015 at 4:15 p.m., al services revealed that the patient's weights ormed and monitored on a would take measures to	1763			

State of GA Inspection Report
STATE FORM

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PRINTED: 09/21/2015 FORM APPROVED

State of GA, Healthcare Facility Regulation Division (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A BUILDING __ C B WING 044-588 08/26/2015 NAME OF PROVIDED OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE LAUREL HEIGHTS HOSPITAL ATLANTA, GA 30306 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1000 Initial Comments. 1000 At the time of the survey, Laurel Heights was in compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth, as a result of complaint investigation #GA 00153717 State of GA Inspection Report LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

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(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			SURVEY LETED	
		044-588	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE	1070	
LAUREL	. HEIGHTS HOSPITAI		RCLIFF ROA , GA 30306			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
I 000 Initial Comments.		1 000				
	At the time of the su was in compliance vand Regulations for Facilities for Childre	urvey, Laurel Heights Hospital with Chapter 111-8-68 Rules Residential Mental Health in and Youth, as a result of tions # GA00178889.				

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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State of GA. Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			SURVEY LETED	
			A. BOILDING			:
		044-588	B. WING		10/05/2017	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
LAUREL	HEIGHTS HOSPITA		RCLIFF ROA ., GA 30306	.D, NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
1 000	Initial Comments.		1 000			2
	was in substantial of 111-8-68 Rules and Mental Health Facil	urvey, Laurel Heights Hospital compliance with Chapter d Regulations for Residential ities for Children and Youth, as it investigation #GA00179764. ency was cited.				
l 829 SS=D)20 Services- Records.	I 829			
	20. Recording. Entries in the clinical records shall be made by all staff having pertinent information regarding the patient, consistent with the facility policies, and authors shall fully sign and date each entry. When mental health trainees are involved in patient care, documented evidence shall be in the clinical records to substantiate the active participation of supervisory clinical staff. Symbols and abbreviations shall be used only when they have been approved by the clinical staff and when there is an explanatory legend. Final diagnosis, both psychiatric and physical, shall be recorded in full, and without the use of either symbols or abbreviations.					
	Based on interviews and review of policion failed to ensure that	net as evidenced by: s, review of medical records, es and procedures, the facility t the medical record reflected ints, interventions and ment.				
	revealed that on 8/3	Review of patient #1's record 30/17 at 8:30 a.m., a telephone the nurse practitioner for an				

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		044-588	B. WING		C 10/05/2017	
	PROVIDER OR SUPPLIER . HEIGHTS HOSPITA	934 BRIA	DRESS, CITY, ST RCLIFF ROA A, GA 30306			
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1829	x-ray of the foot to a report revealed that x-ray of the patient were no abnormalit (breaks). Review a documentation of the complaint. In an interview on a conference room, a practitioner stated a patient #1. He/she medical complaint, medical consult. It consultation form is medical record after of the patients phys. An interview with electron conference room, the facility for a year four (4). Employee 'toe' had been hurt accidentally slamm not recall the outco Employee #2 states to him/her that ano him/her. At the timpatient did not have Employee #2 did not either of these reconstruction.	evaluate foot pain. The x-ray ton 8/30/17 at 11:30 a.m., an #1's foot was taken and there ies noted included fractures of the record did not reveal he nature of patient #1's foot 10/4/17 at 12:15 p.m. in the employee #14, a nurse that he/she did not recall estated that if a patient had a the unit staff would order a He/she stated that a medical completed and placed in the resical complaint. Imployee #2, a therapist, was /17 at 3:15 p.m. in the He/she had been employed at reand was the therapist on unit at 2 recalled that patient #1's by the patient's roommate ing it in the door. He/she did me of the injured foot. If the therapist on the reported that patient #1 had reported there patient had slapped the of the report reported that the earny visible marks or bruising, of recall the exact day or date exported injuries. Imployee #5, the program acted on 10/3/17 at 11:00 a.m. the position since August 1, in the po				
		Illed that patient #1 had a foot ecall the exact nature of the				

State of GA Inspection Report

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		044-588	I #		10/0	5/2017
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1829	injury. In an interview on 1 conference room, e nursing/risk manag incident reports on Review of the facility CRPH4200.0D title reviewed 4/17/17, rowere to be followed appropriately throug responsibility of the physician of any me physician was responsultation. A metobe initiated by the number of the physician of the physician was responsibility of the physician was responsible.	0/3/17 at 10:00 a.m. in the mployee #2, director of er, stated that there were no record for patient #1. y's policy number d 'Medical Consultation', last evealed that medical problems	1829			

State of GA Inspection Report

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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1 000	Initial Comments.		1 000			
	compliance with Ch Regulations for Res	urvey, Laurel Heights was in apter 111-8-68 Rules and idential Mental Health n and Youth, as a result of tion #GA00156477.				

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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B. WING____

11/29/2016

NAME OF PROVIDER OR SUPPLIER

LAUREL HEIGHTS HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE

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ATLANTA, GA 30306

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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

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(EACH CORRECTIVE ACTION SHOULD BE
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DEFICIENCY)

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loop Initial Comments.

At the time of the survey, Laurel Heights Hospital was not in compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth, as a result of complaint investigation #GA00168904. The following deficiency was cited.

1929 111-8-68-.08(2)(c) Emergency Safety SS=G Interventions.

Emergency safety interventions shall not include the use of any restraint or manual hold that would potentially impair the patient's ability to breathe or has been determined to be inappropriate for use on a particular patient due to a documented medical or psychological condition.

This RULE is not met as evidenced by:
Based on review of the facility's policies
and procedures, medical records (#s 110), employee files (#s 1-8), credential
files (#s 12 and 13), videotape of the
incident, staff and patient interviews,
observations and review of facility
seclusion and restraint data, it was
determined that the facility used a manual
hold in a manner that would potentially
impair the patient's ability to breathe
resulting in the death of the patient.

Findings were:

Review of the patient #1's medical record revealed that the patient was admitted to this facility for evaluation and treatment of various psychiatric symptoms and problem behaviors.

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Corrective Action

The DON, Medical Director, and Director of Clinical Services reviewed and revised the policy for Seclusion and Restraint (Policy # CRPM4109.0X) to ensure inclusion of all of the requirements in the rule. The policy was approved by the Governing Body on 12/14/16.

The elements of the revised policy include (Tags N-127; 128; 132; 140; 145; 149; 150; 153; 154; 155; 156; 161; and 165):

- An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.
- Restraint or seclusion must not result in harm or injury to the
- An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).

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NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE

ATLANTA, GA 30306

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his/her functional behaviors such as coping skills and communication since the time of admission three (3) years previously. Patient #1 was currently in the custody of the Department of Family and Children Services (DFCS).

Review of the Nursing Progress Notes revealed that on the day in question, the nurse was called to assess patient #1 as the patient was aggressive toward a peer as evidenced by patient

#1 hitting a peer. Patient #1 required a physical hold/restraints x 2 due to his/her aggressive behavior. The nurse went into the medication room to prepare a medication that was ordered as needed for aggression when a "Code Blue" (an announcement that is used for a

cardiopulmonary [heart/lungs] arrest happening to a patient in a hospital or clinic and requiring a team to rush to a location to begin resuscitative efforts) was announced. The nurse ran to the location and found that cardiopulmonary resuscitation (CPR) was being performed on patient #1. 911 was called and CPR was continued until Emergency Medical Technicians (EMTs) arrived and took over the care of patient

#1. Review of the Transfer/Emergency Services
Progress Note revealed that the patient became
unresponsive with no breathing noted and that CPR
was initiated. Patient #1 was transferred via ambulance
to a local hospital. Efforts to resuscitate patient #1 were
unsuccessful and the patient was pronounced deceased
by the receiving hospital. An autopsy was pending with
a possible diagnosis of aspiration.

Review of patient #1's hold/restraint data revealed that for the previous two (2) months, patient #1 had four (4) holds/restraints-one in September 2016 and three (3) in October 2016 No previous holds/restraints were present for

Orders for restraint or seclusion must be by a physician, permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 are provided under the direction of a physician.

• Within 1 hour of the initiation of the emergency safety intervention a physician, or RN trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to

- The resident's physical and psychological status;
- The resident's behavior;
- B) The appropriateness of the intervention measures; and
- 4) Any complications resulting from the intervention.

• Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

1)Each order for restraint or seclusion as required in paragraph (g) of this section. "As stated in §483.358(g), Each Order for restraint or seclusion must include-" through §483.358(g)(3)"The emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use" and associated Guidance.

2)The emergency safety situation that required the resident to be restrained or put in seclusion.

B)The name of staff involved in the emergency safety intervention.

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1929 Continued From page 2

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November 2016. Review of the data from the two (2) holds that occurred on the day in question revealed that no physician orders or documentation of de-escalation attempts were present.

Review of the facility's policy and procedure entitled "Seclusion and Physical Hold/Restraint," Policy # CRPM4109.0W, revised 08/31/16 revealed that it was the policy of the facility to utilize seclusion and physical hold/restraint only as the last resort in the presence of patient behaviors which are imminently threatening the safety of others or the safety of the patient. Less restrictive interventions are attempted as soon as evidence of behavioral and/or verbal escalation occurs. Only when these early interventions fall and/or the patient has escalated so quickly as to be physically out of control is seclusion or physical hold/restraint initiated. These emergency intervention procedures are never to be used as a means of coercion, discipline, retaliation or for the convenience of staff. All seclusion and physical holds/restraints require an initial order from a physician; and if required, an extension from a physician.

Emergency Safety Interventions (ESIs) will be performed in a manner that is safe, proportionate, and appropriate to the severity of the behaviors, and the patient's chronological and developmental age; size, gender, physical, medical and psychiatric conditions and personal history (including any history of physical or sexual abuse). Precautions should be taken to prevent a patient or staff from sustaining a physical or psychological injury during these emergency intervention procedures. Within 1-hour of the initiation of seclusion or physical hold/restraint, the patient's physical and sychological

4) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.

5) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible.

6) Document in the resident's record the date and time the team physician was consulted.

7) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing, and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.

Staff Education

The Director of Nursing, Director of Risk Management, Director of Education, Therapeutic Foster Care, Chief Financial Officer, Director of Admissions, Director of Clinical Services, and Director of Operations or their designees, began re-training all direct care staff, nursing staff, medical staff, and LIPs on revised policy 12/16/16. Completion date is 12/26/16. The following elements were emphasized during the re-education:

- An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.
- Restraint or seclusion must not result in harm or injury to the resident and must be used only
- An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).
 Orders for restraint or seclusion must be by a physician, permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 are provided under the direction of a physician.

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934 BRIARCLIFF ROAD, NE

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well-being will be assessed by a physician or a licensed professional. The patient's rights, dignity, safety, and well-being will be maintained. 3. Manual Hold/Restrain means the application of physical force, without the use of any device, for the purpose of restricting the free movement of a patient's body. All clinical staff employed at the facility receive training in an approved ESI Course. Staff consistently use these techniques to de-escalate agitated or aggressive patient. Prior to seclusion or physical restraint, all other methods of de-escalation principles and facility practice are used. A refresher training and competency assessment are required twice a year for each clinical employee.

Review of the incident video on 11/28/16 at 2:15 p.m. and 11/29/16 at 10:30 a.m. in the Conference Room, revealed that on 11/20/16 at 12:11 p.m. the patient (#1) is noted to be in the hallway just outside of his/her room where a table was observed to have been placed. The patient was noted to struggle physically with a staff member (#2) and the staff member was noted to be straddling the patient by . sitting on the patient's midsection at 12:12:33. Another staff member (#3) was noted to be kneeling next to the patient at 12:12:43. At 12:13:33, MHA (#4) was observed approaching the two staff members and the patient. At 12:14:40 the MHA (#2) was seen getting off the patient. Continued review of the video revealed the MHA (#4) was noted to be on the patient's back with the patient facing the ground at 12:17:23. The patient was noted to be struggling, and the MHA was seen holding the patient's arms above his/her head. The MHA was observed to continue struggling with the patient while the patient remained face down until

- Within 1 hour of the initiation of the emergency safety intervention a physician, or RN trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to
- 1) The resident's physical and psychological status;
- 2) The resident's behavior;
- 3) The appropriateness of the intervention measures; and
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- 2) The emergency safety situation that required the resident to be restrained or put in seclusion.
- The name of staff involved in the emergency safety intervention.
- 4) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.
- 5) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible.

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	patient over. The patient appears unconscious. The land staff was noted NP (#13) and RN (# day room at 12:20:4 The AED arrived an placed on the patient 12:36:47, and the proom by EMS at 12: During an interview Therapy (DRT, Empon 11/28/16 at 3:11 the DRT revealed the Program (a physical prevention) Instructo provides the staff witholds and methods of facility. The DRT stated administer a horizon (2) staff members admit further stated that the patient was side) while on the graph of the DRT stated that position was contrain pressure to the ches respirations. The Distated that if a patient way that they were staff member was to the DRT also stated stream of the DRT also stated stream of the patient way that they were staff member was to the DRT also stated stream of the patient way that they were staff member was to the DRT also stated stream of the patient way that they were staff member was to the DRT also stated stream of the patient would facedown and stradient way that they were staff member was to the patient way that they were staff member was to the patient way that they were staff member was to the patient way that they were staff member was to the patient way that they were staff member was to the patient way that they were staff member was to the patient way that they were staff member was to the patient way that they were staff member and stradient way that they were staff member was to the patient way that they were staff member and stradient way that they were staff member and the patient way that they were staff member and the patient way that they were staff member and the patient way that they were staff member and the patient way that they were staff member and the patient way that they were staff member way that they were staff member way that they way that they way t	MHA was observed turning the ed to be MHA appeared to be yelling to be running in the video. The ET) were observed running into the IS. CPR was initiated at 12:21:0 d was ent at 12:24:10. EMS arrived attent was transported out the detainent was a certified Minds restraint program used in crisis r. The DRT stated that he/she the training for physical restraint of de-escalation used in the detail was to have no less than two the test of the patient's breathing, on were to be monitored at all ent is in a hold. The DRT stated to be placed laterally (on his/herround or floor. I holding a patient in a face-downdicated as it could cause undust and abdomen and restrict RT ent verbalized or indicated in a le having difficulty breathing, to release the patient immediate ed that there would never be lid justify a patient being hedded. The DRT further stated the	at Monitoring ay 100% of restraint/seclusion documents are moni of Risk or designee to ensure that all elements an within 24 hours. Any variation in practice will re or training and/or disciplinary action up to and incl Aggregate data is reported monthly to the Qualit set Medical Executive Committee monthly and Gov quarterly. Responsible Persons Director of Nursing; Risk Manager; CEO; Director of Nursing; Risk Manager; CEO; Director of Operations; Medical Director of Operations; Medical Director of Operations of Medical Director of Operations of Appropriate and Protective skills, and therapeutic holds. The review Handbook of Visual Depictions of Appropriate Restraint, as well as, included the following: 1) Use Communication first. Communication is the restrictive approach towards preventing aggressing. 2) Only use a physical restraint or hold as a last restraint. Harming themselves	safety interventions g, and monitoring the sident and the safe use gency safety tored by the Director re correctly complete esult in additional uding termination. ty Council and verning Board ctor of Clinical tor tidelines for Physical unication skills, ew provided Mindset Technique of Physica the first and least ion. resort when the child

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	received a six (6) mapproximately four a stated that a six (6) given. The ORT addincluded a demonstrany staff member no practice, it was alwa courses. During the course of asked to view the victime, which the ORT portion of the interviviewing his/her weight appropriate. When a that placing weight of constrict the patient should never have a and the MHA should have asked MHA (#4) was hold administering a horizindicated the hold was appropriately. When MHA should have new When asked why the the MHA could cause and restrict breathing staff has been taughthold cannot be applied. The DRT added that observing and assisting the output of th	tion. and that all employees onth refresher course that was and a half (4.5) hours. The ORT hour annual training is also ded that the testing ation and a written test, and if reded further Instruction or anys offered during the the interview, the ORT was deeped for the incident for the first agreed to do. The following and the was conducted after the lew. IMA (#2) should have straddled are weight, the ORT stated that at on the patient was not asked why the ORT explained on the patient in that way could be breathing and cause undue. The ORT added that the MHA approached the patient alone, for assistance. When asked if ing the patient correcting while contal hold, the MHA as not done correctly or asked why the ORT stated the ver been on the patient's back. ORT indicated the weight of a undue injury to the patient. The ORT stated that the to release the patient if the	*If there is physical distressADJUST or RELI 11) Do not lecture, threaten, or try to discipline a physical restraint. 12) Avoid engaging in general conversation with	ing to the floor njury for staff and the o a child-avoid using physical and trust. It teaches that it to keep them safe. ng over a child's head we body positions: athing and it can re- or have any type of cal restraint. The my part of a child's t your entire body in the floor. the child's: EASE THE HOLD a child during a

handled correctly.

During an interview with the Director of Nursing

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ATLANTA, GA 30306

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (XS) COMPLETE DATE

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(DON) (#11) on 11/29/16 at 1:55 p.m. in the Conference Room, the DON revealed that the first time the patient (#1) was restrained at approximately 12:11 p.m. on 11/20/16, no MD order for the restraint was obtained due to the ongoing situation with the patient. The DON

stated that after second restraint hold in the day room, the RN (#7) was trying to get a medication to administer to the patient, and a code blue was called. The DON stated that subsequently, an order for the restraint was never obtained.

During an interview with the MD (#14) on 11/29/16 at 2:10 p.m. in the Conference Room, the MD stated he/she was informed about the restraint after the incident, but the MD stated he/she had never been called about obtaining an order for the restraint. The MD explained that orders that needed to be signed were placed in his/her box. When asked if the MD had received any paperwork regarding the restraint for the patient on 11/20/16, the MD stated he/she had not.

Review of the videotape and interview with the Mindset instructor (employee #1) during the viewing of the videotape revealed that the holds/restraints on the day in question with patient #1 were done incorrectly. The facility was unable to tell the surveyors how often or even if the videos of the milieu were reviewed on a regular basis in order to assure that the holds/restraints performed by the staff were done properly. Review of the employee files revealed that all employees involved in the incident had received hold/restraint training according to the facility's policy, but the

facility falled to monitor whether staff were performing those holds/restraints according to their Mindset

Staff Education

Unit 7 direct care staff were re-educated by Certified Mindset Instructors on the management of aggressive behavior techniques including the review of communication skills, protective skills, and therapeutic holds, as well as, verbal de-escalation. Mindset Skills Assessments were re-issued. Unit 7 retraining was completed as of 12/7/16

100% of active facility staff has been re-educated on the Critical Guidelines for Physical Intervention, as well as, provided Mindset Handbook of Visual Depictions of Appropriate Technique of Physical Restraint as of 12/16/16.

Monitoring

Certified Emergency Safety Intervention Instructors or designee will review 100% of physical holds that are viewable on surveillance camera to review correct use of trained techniques. Staff identified as not meeting standards for correct technique will be provided additional training in individual or group settings. Ongoing non-compliance will be addressed through disciplinary action up to and including termination. Aggregate data is reported monthly to the Quality Council, Medical Executive Committee and quarterly to the Governing Body.

Responsible Persons

Director of Nursing; Risk Manager; Director of Clinical Services; Director of Operations;

Certified Emergency Safety Intervention Instructors

training.

PRINTED: 09/24/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		11L005	B. WING_		11	C /29/2016
NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306		.	11/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 000	Initial Comments		N O	00		
	was not in complian Participation 483.3 Participation for the Seclusion in Psych Facilities Providing for Individuals Undainvestigation of compone compliance cauten (10) identified sat 2:45 p.m., an imwas identified. The the Chief Operating Clinical Services (DResources (DHR), Director of Operation of this IJ on 11/28/10 On 11/29/16 at 10:0 of Action and Risk presented to the suthe following: Action Item #1 Progressive discipling directly involved in include written coundetermined appropathe investigation. Ediscipline will be maccompletion date; 1 Update: One (1) or involved in the incide.	HS Corporation were informed 16 at 4:15 p.m. 15 a.m., an Organization Plan Reduction Strategies was reveyors. The Plan consisted of the incident will be taken to inseling up to termination as riate pending the completion of Evidence of progressive aintained in personnel files.				
ABODATORY		FR/SUPPLIER REPRESENTATIVE'S SIGNA	TUDE	TITLE		(X6) DATE

01/10/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		11L005	B. WING	· ·	l l	C /29/2016
	PROVIDER OR SUPPLIER HEIGHTS HOSPITA	_		STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
N 000	Action Item #2 Direct care staff will protocols in conductobservation rounds accurate document communication. Recon 11/21/16 and to Staff performance will be conducted in a minimum of once 11/29/16 Update: I Operations (DOO) and obtain verbal conducted during and adequate observations, accur hand-off communications overseen by DOC and utilize immediated Leadership Team and Leadership Rounds feedback to the empthat the employee from will then be turn determine the approtocomplete all actions.	be re-educated on the facility ting appropriate and adequate including timely observations, ation, and hand-off e-education has been initiated be completed by 12/02/16. Fill be monitored through the end observation round audits a person and camera review at per shift per unit per week. In process. The Director of continues to provide education bunseling checklist (attached), and on conducting appropriate rivation rounds including timely atte documentation, and ation. Re-education will be ach shift change meeting that or designee. Will develop the counseling form for and others to use when doing as the ployee and require a signature has been re-educated. The med into HR/Manager to opriate action to address. Date	NO			
	presence of person has been imitated of	al cell phones. Re-education on 11/21/16 and is to be 2/16. Staff compliance will be				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		11L005	B. WING		11	C /29/2016
	PROVIDER OR SUPPLIER - HEIGHTS HOSPITA	\L	,	STREET ADDRESS, CITY, STATE, ZIP COE 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306		,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 000	monitored through observation round person and camera per shift per unit per 11/29/16 Update: provide education checklist (attached copy of Dress Cod Guidelines for Prof Conduct Policy will Medical Executive employees by 12/1 Action Item #4 Automated Externa will be re-located to care staff will be reemergency medica machine to be com Update 11/19/16: to provide access to Education with stat track by 12/12/16. HR file. Action Item #5 Nursing and direct on the facility protoresponse and staff medical codes. Codocumented and refiles. Re-education Update 11/19/16: assigned to resporbringing AED and Team will review ar	the senior leadership and audits will be conducted in a review at a minimum of once er week. In process. DOO continues to and obtain verbal counseling.). Reviewed and provided a e ((MHR9015.0D) and ressional Conduct. Professional be adopted and approved by Committee and trained to all	N C			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		11L005	B. WING_		ŀ	C /29/2016	
	NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
N 000	competencies for di include a schedule and quarterly Code review and update postaff on updated and updated on the updated on the updated on the updated on the updated on upd	of monthly Code Blue drills Ten drills and scenarios. Will policy in PI 11/30/16. Educate plicies by 12/12/16. aff will be re-educated on the gressive behavior techniques and Verbal De-escalation by date of completion 12/02/16. Buidelines for Physical eviewed with all staff on duty s, email All direct care staff will be management of aggressive s and Verbal De-escalation by rovement Team on the facility e regarding restraint and tablished by 11/30/16. Team the the identified senior leaders	NO				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		11L005	B. WING		11	C /29/2016
	PROVIDER OR SUPPLIER . HEIGHTS HOSPITA	L		STREET ADDRESS, CITY, STATE, ZIP CO 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 000	phone issues regar from Unit 7. 11/19/16 Update: 0 have adequate capand outgoing phone Action Item #10 All staff will be re-ed Guidelines for Physprovided Mindset Hof Appropriate Tech Documentation will files by 12/02/16, Update: This proceuse The IJ was removed USE OF RESTRAIL CFR(s): 483.354 Subpart G: Condition of Restraint and Se Residential Treatment Psychiatric Services Twenty One. This CONDITION is Based on review of procedures, medicatiles (#s 1-8), crede videotape of the incinterviews, observations and restraint and restraint and restraint and se Residential Treatment Psychiatric Services Twenty One.	gh investigation into reported ding access and dropped calls. Completed. Verified that we acity to manage all incoming e calls. ducated on the Critical ical Intervention as well as andbook of Visual Depictions nique of Physical Restraint. be maintained in personnel less was started 11/28/16. d on 11/29/16 at 10:15 a.m. NT AND SECLUSION on of Participation for the Use clusion in Psychiatric ent Facilities Providing Inpatient is for Individuals Under Age s not met as evidenced by: If the facility's policies and all records (#s 1-10), employee ntial files (#s 12 and 13), ident, staff and patient tions and review of facility aint data, it was determined	N 0			
	patient during a res	d to ensure the safety of a traint, resulting in the death of dition was cited at N-0100 and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:			TIPLE CONSTRUCTION NG	CO	(X3) DATE SURVEY COMPLETED C	
	11L005	B. WING			/29/2016	
NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306	Ē		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
acceptable Credible Al 11/29/16 at 10:15 a.m N-132, N-140, N-145, N-154, N-155, N-156, in the Condition non-crimdings were: Review of the patient # that the patient was acceptable and problem and problem Patient #1 was current behavior therapy and this/her functional behavior therapy and communication sithree (3) years previous currently in the custod Family and Children Signal Review of the Nursing that on the day in questo assess patient #1 at toward a peer as evided peer. Patient #1 required to a peer as evided peer. Patient #1 required to the medication that was on aggression when a "Communication that was on aggression when a "Communication to begin result in the period of the peer."	The facility provided an Illegation of Compliance on Tags N-127, N-128, N-149, N-150, N-153, N-161 and N-165 resulted compliance to be made. #1's medical record revealed dmitted to this facility for ent of various psychiatric m behaviors. #1'ly receiving intensive multiple efforts to increase aviors such as coping skills nce the time of admission asly. Patient #1 was by of the Department of Services (DFCS). Progress Notes revealed stion, the nurse was called so the patient was aggressive enced by patient #1 hitting a red a physical hold/restraints ressive behavior. The nurse on room to prepare a redered as needed for ode Blue" (an used for a cardiopulmonary ppening to a patient in a equiring a team to rush to a	N 1				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		COMPLETED	
		11L005	B. WING		11	C /29/2016	
NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306			11/25/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
N 100	was being performed called and CPR was Medical Technician the care of patient and the care of patient are revealed that the payoff the care of patient are revealed that the payoff that the payoff that the payoff that the patient was pronour receiving hospital. Patient was pronour receiving hospital. Possible diagnosis Review of patient and four (4) holds/restraints were review of the data occurred on the seculation attention and the last resort in the which are imminentially interventions are at of behavioral and/owhen these early in patient has escalate physically out of co	ed on patient #1. 911 was s continued until Emergency s (EMTs) arrived and took over #1. Review of the y Services Progress Note atient became unresponsive oted and that CPR was 1 was transferred via al hospital. Efforts to #1 were unsuccessful and the need deceased by the An autopsy was pending with a of aspiration. 1's hold/restraint data revealed two (2) months, patient #1 restraints-one in September in October 2016. No previous re present for November 2016. from the two (2) holds that y in question revealed that no documentation of	N 1				

NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION				TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOSPITAL (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 100 Continued From page 7 intervention procedures are never to be used as a means of coercion, discipline, retaliation or for the convenience of staff. All seclusion and physicial holds/restraints require an initial order from a physician; and if required, an extension from a physician. Emergency Safety Interventions (ESIs) will be performed in a manner that is safe, proportionate, and appropriate to the severity of the behaviors,			11L005	B. WING		11	C /29/2016	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 100 Continued From page 7 intervention procedures are never to be used as a means of coercion, discipline, retaliation or for the convenience of staff. All seclusion and physical holds/restraints require an initial order from a physician; and if required, an extension from a physician. Emergency Safety Interventions (ESIs) will be performed in a manner that is safe, proportionate, and appropriate to the severity of the behaviors,			L	934 BRIARCLIFF ROAD, NE				
intervention procedures are never to be used as a means of coercion, discipline, retaliation or for the convenience of staff. All seclusion and physical holds/restraints require an initial order from a physician; and if required, an extension from a physician. Emergency Safety Interventions (ESIs) will be performed in a manner that is safe, proportionate, and appropriate to the severity of the behaviors,	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI)	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION	
age; size, gender, physical, medical and psychiatric conditions and personal history (including any history of physical or sexual abuse). Precautions should be taken to prevent a patient or staff from sustaining a physical or psychological injury during these emergency intervention procedures. Within 1-hour of the initiation of seclusion or physical hold/restraint, the patient's physical and psychological well-being will be assessed by a physician or licensed professional. The patient's rights, dignity, safety, and well-being will be maintained. 3. Manual Hold/Restrain means the application of physical force, without the use of any device, for the purpose of restricting the free movement of a patient's body. All clinical staff employed at the facility receive training in an approved ESI Course. Staff consistently use these techniques to de-escalate agitated or aggressive patient. Prior to seclusion or physical restraint, all other methods of de-escalation principles and facility practice are used. A refresher training and competency assessment are required twice a year for each clinical employee. Review of the incident video on 11/28/16 at 2:15	N 100	intervention proced means of coercion, convenience of staff holds/restraints req physician; and if rec physician; and if rec physician. Emergency Safety performed in a man and appropriate to and the patient's chage; size, gender, psychiatric condition (including any histor Precautions should or staff from sustain injury during these procedures. Within seclusion or physical and psycheassessed by a physical and psycheassesses of any devict the free movement. All clinical staff emptraining in an approconsistently use the agitated or aggress or physical restraint de-escalation princiused. A refresher transport of the process or physical restraint de-escalation princiused. A refresher transport of the process or physical employee.	ures are never to be used as a discipline, retaliation or for the f. All seclusion and physical uire an initial order from a quired, an extension from a quired, an extension from a finterventions (ESIs) will be uner that is safe, proportionate, the severity of the behaviors, pronological and developmental physical, medical and uns and personal history rry of physical or sexual abuse). The betaken to prevent a patient uing a physical or psychological emergency intervention and hold/restraint, the patient's pological well-being will be sician or licensed professional. In dignity, safety, and well-being and manual Hold/Restrain on of physical force, without the patient's body. Soloyed at the facility receive wed ESI Course. Staff use techniques to de-escalate in exercise techniques to de-escalate in patient. Prior to seclusion and facility practice are raining and competency quired twice a year for each	N 1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		11L005	B. WING			C /29/2016
NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306		20,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
N 100	Conference Room, 12:11 p.m. the patic hallway just outside was observed to ha was noted to strugg member (#2) and the straddling the pamidsection at 12:12 (#3) was noted to be at 12:12:43. At 12:10 observed approaching the patient. At 12:11 getting off the patient video revealed the Note the patient's back we ground at 12:17:23 struggling, and the patient's arms above observed to continually while the patient reresponded to the Note of the patient over. The patient over at 12:21:03. The Athe patient at 12:24 and the patient was by EMS at 12:45:15. During an interview Therapy (DRT, Employer Conference Room, was a certified Minor	at 10:30 a.m. in the revealed that on 11/20/16 at ent (#1) is noted to be in the of his/her room where a table we been placed. The patient ple physically with a staff ne staff member was noted to atient by sitting on the patient's 2:33. Another staff member e kneeling next to the patient 13:33, MHA (#4) was ing the two staff members and 14:40 the MHA (#2) was seen int. Continued review of the MHA (#4) was noted to be on with the patient facing the inthe patient was noted to be MHA was seen holding the e his/her head. The MHA was see struggling with the patient mained face down until MHA was observed turning the atient appeared to be with appeared to be with appeared to be yelling to be running in the video. RN (#7) were observed running to 12:20:45. CPR was initiated ED arrived and was placed on 1:10. EMS arrived at 12:36:47, a transported out the day room	N 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
N 100	the staff with training and methods of de- The DRT stated that a horizontal was to members administed stated that the pattern was to be plushile on the ground holding a patient in contraindicated as it to the chest and ab respirations. The Duverbalized or indicated that there would justify a patient stated that the patient stated that the patient stated that the patient stated that the patient stated that	I stated that he/she provides g for physical restraint holds escalation used in the facility. It the correct way to administer have no less than two (2) staffering the hold. The DRT further ient's breathing, airway, and be monitored at all times while bold. The DRT stated that the faced laterally (on his/her side) or floor. The DRT stated that a face-down position was to could cause undue pressure domen and restrict RT stated that if a patient ted in any way that they were eathing, the staff member was not immediately. The DRT also wild never be a situation that int being held facedown and T further stated that all staffey, fourteen (14) hour full holds and de-escalation, and eceived a six (6) month at was approximately four and a e DRT stated that a six (6) g is also given. The DRT mg included a demonstration and if any staff member needed or practice, it was always offered of the interview, the DRT was dee of the incident for the first agreed to do. The following ew was conducted after the	N 1			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		11 L 005	B. WING		C 11/29/2016
NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		LD BE COMPLETION
N 100	stated that placing I was not appropriate explained that placinway could constrict cause undue injury added that the MHA approached the pat should have asked MHA (#4) was holdi administering a horithe hold was not do When asked why the have never been on asked why the DRT MHA could cause u restrict breathing. Thas been taught to cannot be applied of the staff members wassisting the hold sithat the hold was not During an interview (DON) (#11) on 11/2 Conference Room, time the patient (#1 approximately 12:1 order for the restrain ongoing situation wistated that after sec room, the RN (#7) with administer to the called. The DON st	of with his/her weight, the DRT his/her weight on the patient. When asked why the DRT higher weight on the patient in that the patient's breathing and to the patient. The DRT is should never have lient alone, and the MHA for assistance. When asked if higher the patient correcting while expected and the patient correcting while expected and the patient's back. When indicated the weight of the induce injury to the patient and the DRT stated that the staff release the patient if the hold correctly. The DRT added that who were observing and should have alerted the MHA of being handled correctly. with the Director of Nursing 29/16 at 1:55 p.m. in the the DON revealed that the first	N 1		
	at 2:10 p.m. in the o	with the MD (#14) on 11/29/16 Conference Room, the MD nformed about the restraint ut the MD stated he/she had			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		11L005	B. WING			C / 29/2016	
	PROVIDER OR SUPPLIER . HEIGHTS HOSPITAI	<u></u>		STREET ADDRESS, CITY, STATE, ZIP C 934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306		11/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
N 100	restraint. The MD eneeded to be signed. When asked if the Mpaperwork regarding on 11/20/16, the MIReview of the video Mindset instructor (viewing of the video holds/restraints on the H1 were done income to tell the surveyors of the milieu were recorder to assure that by the staff were done employee files reveal involved in the incidental training according to facility failed to months.	bout obtaining an order for the explained that orders that d were placed in his/her box. MD had received any g the restraint for the patient D stated he/she had not. tape and interview with the employee #1) during the tape revealed that the the day in question with patient rectly. The facility was unable how often or even if the videos eviewed on a regular basis in the holds/restraints performed ne properly. Review of the aled that all employees lent had received hold/restraint to the facility's policy, but the itor whether staff were olds/restraints according to	N 1	00			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE : COMP	X3) DATE SURVEY COMPLETED	
		044-588	B. WING		12/2	; 1/2017
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE	1 12/2	
LAUREL	. HEIGHTS HOSPITAI		RCLIFF ROA , GA 30306	AD, NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
1 000	Initial Comments.		1 000			A _ 6 7
	At the time of the su was in compliance wand Regulations for	urvey, Laurel Heights Hospital with Chapter 111-8-68 Rules Residential Mental Health in and Youth, as a result of tion #GA00182161.				

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE